and technology needed to accomplish this extension of life expectancy in the latter years of life have been costly, especially when added to other environmentally imposed related costs such as those just mentioned above. And there is certain to be more of all this for the foreseeable future.

Victor Fuchs, professor of economics at Stanford University, has noted that in 1935, when the age of eligibility for social security retirement benefits was set at 65, life expectancy at age 65 was about what it is now at age 72. He suggests that old age now be redefined to start at age 72. In many ways this might be an eminently sensible idea. It seems to ring true. It is simple and could be accomplished with the strokes of Congressional and Presidential pens (alas, except for the political and emotional hue and cry that would surely be raised). But realistically it would preserve the intent of Medicare, substantially reduce its costs and significantly add to its income in relation to benefits paid out. It would also recognize for the public the really great payoff we have received for our national investment in medicine and patient care, a payoff that has been a national objective for nearly four decades.

But could something like this ever happen? Yes, it could, but probably will not. In our system, institutional memories are short. Governments tend to respond to self-interest pressure groups and what they perceive to be public opinion. Too often they have difficulty thinking or planning beyond the next election—never more than a few years away. It is more likely that the Medicare program will continue to be progressively overburdened and progressively underfunded, and that its value to those it was designed to serve will progressively diminish. There are times when radical surgery can prolong life, and even quality of life. This could be one of those times for Medicare.

MSMW

Medical Workups Before Eye Operations

MANY HAVE DEPLORED "cookbook" medicine and rebel against "routine" protocols for the evaluation of patients or specific conditions. Nevertheless, standardization in the approach in health care is often useful and may be cost-effective. In the interesting article by Levinson on preoperative evaluations, elsewhere in this issue, the data and analysis by the author suggest that there is a well-founded basis for the routine preoperative evaluation for patients undergoing eye surgery in a general community hospital. This paper is welcome because of the unusual nature of the subject: an attempt to look at the cost-effectiveness of that medical workup. The author is to be commended for her efforts. She concludes that the relatively modest costs of an internal medicine consultation and ordering of laboratory tests, based on the consulting physicians' findings, are most reasonable, given the overall expense to the patient for the ophthalmologic procedure itself. It is difficult to take exception to an evaluation that costs an average of $150 and that may be beneficial to a number of patients, considering that the overall hospital stay costs many thousands of dollars.

One cannot translate the results of this study into general preoperative evaluations. Eye operations are certainly less stressful than abdominal or thoracic procedures, which are more common surgical procedures in patients older than 60 years. It would appear that many of these patients may not have had ongoing care by a primary care physician, such as an internist or family practitioner. This is not necessarily true for many older patients who have serious medical problems requiring a surgical procedure, and therefore this population might be somewhat skewed, representing a group of persons who are receiving relatively little ongoing medical care. Unfortunately, no information is made available about whether the patients in this study had private physicians.

While I agree that considerable benefit was derived from the evaluations, particularly with respect to the identification of "incidental conditions" and to the fine tuning of the patients with respect to problems such as electrolyte imbalance, rapid atrial fibrillation or anemia, it is not at all clear that these routine evaluations did in fact decrease morbidity and mortality.

Significant postoperative problems were noted in eight patients. Five had apparently been screened and found to be free from significant problems by the internist before operation. The problems that arose in the other three were not related to the preoperative "risk condition" except for the single patient who had rapid atrial fibrillation postoperatively. In addition, of the three patients with so-called life-threatening complications, *none* had a risk factor identified in the preoperative evaluation. Thus of the 11 patients with major perioperative or postoperative complications, only 1 was identified before the operation as being at high risk (atrial fibrillation), and in this patient the intervention by the internist was not enough to prevent the rapid ventricular response. Of course, one could argue that delaying operations in four patients and identifying other health problems justifies the use of internists in evaluating these patients. As Dr Levinson points out in her discussion, the preoperative setting is not the most appropriate situation for a general evaluation of a patient. The follow-up for patients who were found to have previously unknown abnormalities is not clear and therefore an intervention by the consultant may well have had no lasting impact on the health care for these patients.

I do not suggest that the 20% of patients with a risk condition identified preoperatively were not benefited by the consultation, laboratory tests and therapeutic interventions. One would hope that an ophthalmologist could have identified most of the serious surgical risk conditions without consultation by an internist. This certainly would include the patients with a significant arrhythmia, recent heart attack, syncopal episode or pulmonary embolism or hypokalemia.

In conclusion, I agree with Dr Levinson that the

evaluations were relatively cost effective, given the overall expense of the operative procedures. I also concur that routine interventions in eye surgery patients should be limited only to those persons older than 50. Greater cost-effectiveness could have been achieved if the ophthalmologists had called for consultation in only those patients with significant surgical risk, as identified by history or by laboratory evaluation. It would appear that the routine evaluations were of benefit to the ophthalmologists to help avoid complications, but it does emphasize the narrow focus of specialists in medicine, and one wonders if good common sense and attention to details might not be even more cost-effective than calling internists in routinely.

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Medical Practice Question

EDITOR'S NOTE: *From time to time medical practice questions from organizations with a legitimate interest in the information are referred to the Scientific Board by the Quality Care Review Commission of the California Medical Association. The opinions offered are based on training, experience and literature reviewed by specialists. These opinions are, however, informational only and should not be interpreted as directives, instructions or policy statements.*

Cardiac Pacemakers

QUESTION:

What are the criteria or indications for the use of cardiac pacemakers?

OPINION:

In the opinion of the Scientific Advisory Panels on Chest Diseases, General Surgery and Internal Medicine, implantation of cardiac pacemakers is considered established medical practice for the following conditions:

- Acquired complete atrioventricular (AV) heart block with or without symptoms.
- Congenital complete heart block with symptoms or bradycardia, or both.
- Bifascicular or trifascicular block with syncope attributable to transient complete heart block after other causes of syncope are excluded.
- Second-degree AV heart block of Mobitz type II with symptoms attributable to intermittent complete heart block.
- Asymptomatic second-degree AV block of Mobitz type II.
- Substantial sinus bradycardia caused by long-term necessary drug treatment.
- Recurrent and refractory ventricular tachycardia.
- In patients recovering from acute myocardial infarction with temporary complete or Mobitz type II second-degree AV block.
- Second-degree AV heart block of Mobitz type I with significant symptoms due to resulting hemodynamic instability.

In addition to these indications, there are other conditions which may warrant implantation on an individually determined basis:

- Symptomatic sick sinus syndrome.
- Symptomatic carotid hypersensitivity syndrome.
- Selected asymptomatic patients with sick sinus syndrome (such as those with pauses longer than 3 or 4 seconds).
- Bradycardia-tachycardia syndromes.

Pacemaker implantation may be deemed necessary in many other unique circumstances not included in the above list. Such individually determined decisions to implant permanent pacemakers must also be presumed to be appropriate practice.